THE MEDICAL SECURITY PROGRAM

Health Insurance Benefits for Unemployment Insurance Claimants

Official Use Only: Do not write in this space.

Instructions:

Before you mail your claim form, please remember to:

- Complete the entire form; and
- Attach the required documents; and
- Mail the form to the DWD address listed below:

Department of Workforce Development
MSP Customer Service
P.O. Box 146758
Boston, MA 02114-0020

Required Documentation:

1. **Proof of Monthly Premium:** **(required only for the first premium reimbursement request or if the premium amount changes)**
   - Copy of your premium bill that states name of subscriber, amount of premium and billing period; or
   - A copy of your COBRA letter on company letterhead stating name of subscriber, amount due, and billing period; or
   - A copy of your payment coupon for month(s) requesting reimbursement if it states name of subscriber, company and amount due.

and

2. **Proof of Payment:** **(required for each month requesting reimbursement)**
   - A copy of a canceled check (front and back); or
   - Receipt of payment on company letterhead specifying the amount and month paid; or
   - A copy of a money order or bank check.

Important

- Copies cannot be kept on file. Please make copies for your records before mailing the documents.
- In order to be reimbursed you must be responsible for 100% of the entire monthly insurance premium.
- All claims must be submitted within one year of the payment.
- The reimbursement you receive will never be more than the premium you pay.
- Reimbursement will only be made after the end of the month for which the premium was paid.

Premium Assistance Information

Social Security Number:_____

Subscriber's Name:_____
Last First Middle Initial

Address:_____
Street City State Zip Code

Name of Health Insurance Co.:_____

Coverage Type (Check One): __Individual Plan __Family Plan

Month Requesting Reimbursement for:	Monthly Premium Amount Paid:
Dates(s) From: xx/xx/xxxx To: xx/xx/xxxx	

Claimant Signature_____ Date_____